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Health and Human
Services Commission

House Committee on Human Services

Child Protective Services Reform

October 7, 2004

CPS Reform
Presentation Overview

- Executive Order RP 35 Overview
- Child Protective Services Reform
  - OIG Compliance Review
  - HHSC Reform Activities

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Governor's Executive Order RP 35

Overview of Governor's Executive Order

- Executive Order RP35 was issued on July 2, 2004, in response to reports that indicate systemic problems within the Child Protective Services (CPS) program
  - The order directs the Health and Human Services Commission (HHSC) to oversee the systemic reform of the CPS program of the Department of Family and Protective Services (DFPS)
  - Specific actions and outcomes required under the executive order:
    - Review of case files;
    - Administrative practices and organizational structure;
    - Partnering with law enforcement & local communities; and
    - Review of state laws and policies.

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HHSC Response

Timeline:

- Implementation plan submitted to Governor – October 1, 2004
- Final report due on December 31, 2004, will include:
  - A review of all actions taken to address deficiencies; and
  - Recommendations for legislative action.

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CPS Review

Overview:

- HHSC charged the Office of Inspector General (OIG) to conduct a compliance review
  - Entailed a reading of over 2200 cases
- Program Operations Review of all aspects of CPS
- Independent Review of National Practices

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OIG Review

- OIG's review was used as a diagnostic tool to provide HHSC information needed to analyze the issues and identify steps needed to address them
- Overall, OIG findings indicate
  - Policies and procedures appear sound
  - Staff, however, often did not comply with policies and procedures
  - OIG concluded the result of caseworkers' failure to do so is being overwhelmed with the volume of work

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CPS Workload

- Average caseloads for investigators have risen from 47.9 in November 2001 to 61.4 in August 2004
- Nearly four out of ten new caseworkers quit within the first year
  - The turnover rate for new investigative staff exceeds 51%
- Supervisor tenure in the CPS program decreased from about 12 years to 9 years in a two year period

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CPS Program Operations Review

- Initial phase of review identified six key areas for improvement:
  - Reduce caseloads
  - Maintain a well-trained workforce
  - Retain experienced staff
  - Ensure compliance with CPS policies and procedures
  - Develop effective community partnerships
  - Ensure child centered outcomes

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Independent Review

- HHSC will utilize an organization with a national view of child welfare systems to evaluate HHSC's review and provide additional guidance
- The review will focus on:
  - Use of specialized caseworkers
  - Effective models for investigations of child abuse and neglect
  - Comparative review of county and state administered child welfare systems
  - Role of non-governmental organizations in child placement functions
  - Identification of best practices in child welfare

HHSC Immediate Corrective Actions

- Accelerating the hiring of 123 new positions, focusing on investigation caseworkers and supervisors, and child safety specialists
- Provide incentive payments to retain experienced caseworkers in the CPS investigation units
  - Tenured CPS employees who chose to stay or move back to investigations will be eligible for $3,000 after 12 months of service in those units
- Direct CPS caseworkers to refer uncooperative families to local prosecutors for appropriate legal action
  - Example – obtain court order to require parents to participate in services or place the child in foster care

HHSC Immediate Corrective Actions

- Require an independent review before closing cases involving younger children, especially 3 years and under, when abuse and neglect cannot be ruled out
- Provide caseworkers access to medical professionals for immediate consultation and determination on a child's well-being
- Train investigative caseworkers in the use of forensic photography for improved case review, documentation, and medical assessments

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Next Steps

- Combined results from the OIG review, program operations evaluation, and the independent review will form the basis for corrective actions and recommendations for the legislature

- Final report, due December 31, 2004, will include:
  - complete review of CPS
  - implementation plan for additional program improvements
  - Recommendations for legislative actions

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Summary

- HHSC has collected and reviewed information to determine the scope of the problem and what actions need to take place
- HHSC has taken immediate action to protect children at risk and will continue to implement improvements to the CPS program
- Child abuse is too big for an agency to solve. We are dependent on other agencies, the judicial system, and on communities to work together to prevent and respond effectively to child abuse and neglect in Texas

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CPS Case Reviews

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CPS Case Review

- July 12, 2004 -Team of 30 deployed to Arlington
- Statewide random sample of cases
  - Cases were read by CPS staff under guidance of Office of Inspector General (OIG) Internal Affairs personnel
  - Case reading staff results were audited by OIG auditors and HHSC Internal Audit
  - Random field reviews and employee interviews were done by OIG field staff in the General Investigations Division

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CPS Case Review

- Auditing of CPS cases for compliance with CPS policies, procedures, documentation, and reporting standards
  - ➢ OIG reviewed a total of 2,221 CPS investigation case files statewide
    - OIG reviewed 1,103 from Region 3 – Arlington

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CPS Case Review

Case Review Findings:

- CPS caseworkers are inundated with increasing caseloads
  - Resulting in noncompliance with policies and premature closing of cases
- CPS policy is not consistently applied across the state
- CPS caseworkers, in more than ½ of investigations:
  - did not maintain required contact with the child;
  - did not involve a supervisor for appropriate support and direction; and
  - did not provide all the needed services to the children.

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CPS Case Review

Other Findings:

- Face-to-face contact with a child and family within the time frame set by CPS policy was not being followed
- Service plans for further services and actions did not always adequately address the issues of abuse or neglect as identified in the investigation
- CPS did not always initiate or maintain contact with clients referred for the Family Based Safety Services
- Higher level CPS administrators were not involved in exceptionally difficult or complex investigations
- Subsequent referrals continue to present reoccurring issues not resolved in previous cases
- CPS did not maintain regular contact with children placed in foster care

Ongoing OIG Review Efforts

- OIG is continuing to review:
  - CPS quality assurance processes
  - Community perception of CPS
  - Program's relationship with community
  - First line staff recommendations to improve services